California Simulation Alliance (CSA)
Simulation Scenario Template

The California Simulation Alliance (CSA) is comprised of simulation users from all disciplines from throughout the state. Several regional collaboratives have formed totaling 7 as of March, 2011: The Rural North Area Simulation Collaborative (RNASC), the Capital Area Simulation Collaborative (CASC), the Bay Area Simulation Collaborative (BASC), the Central Valley Simulation Collaborative (CVBSC, the Southern California Simulation Collaborative (SCSC), the Inland Empire Simulation Collaborative (IESC), and the San Diego Simulation Collaborative (SDSC). The CINHC, a non-profit organization focused on workforce development in healthcare provides leadership for the CSA.

The purpose of the California Simulation Alliance (CSA) is to become a cohesive voice for simulation in healthcare education in the state, to provide for inter-organizational research on simulation, to disseminate information to stakeholders, to create a common language for simulation, and to provide simulation educational courses. The goals of the alliance will include providing a home within the CINHC for best practice identification, information sharing, faculty development, equipment/vendor pricing agreements, scenario development, sharing and partnership models. More information can be found on the CSA website at www.cinhc.org/programs.

All scenarios have been validated by subject matter experts, pilot tested and approved by the CSA before they were published online. All scenarios are the property of the CINHC/CSA. The writers have agreed to release authorship and waive any and all of their individual intellectual property (I.P.) rights surrounding all scenarios. I.P release forms can be found at www.bayareanrc.org/rsc and click documents. (Please send signed I.P. release forms to KT at kt@cinhc.org)

TABLE OF CONTENTS

SECTION I SCENARIO OVERVIEW

- **A. Title**
- **B. Summary**
- **C. Evidence Base**

SECTION II CURRICULUM INTEGRATION

- **A. Learning Objectives**
  - **1. Primary**
  - **2. Secondary**
  - **3. Critical Elements**
- **B. Pre-scenario learner activities**

SECTION III SCENARIO SCRIPT

- **A. Case Summary**
- **B. Key Contextual Details**
- **C. Scenario Cast**
- **D. Patient/Client Profile**
- **E. Baseline patient/client simulator state**
- **F. Environment / equipment / essential props**
- **G. Case flow /triggers / scenario development**

SECTION IV APPENDICES

- **A. Health Care Provider Orders**
- **B. Digital Images of Manikin / Milieu**
- **C. Debriefing Guide**

SECTION I: SCENARIO OVERVIEW

Scenario Title:	Post-operative assessment_Case A
Original Scenario Developer(s):	Colleen O'Leary-Kelley RN, PhD, CNE
Date - original scenario	03-16-09
Validation:	3-09 K. Bawel-Brinkley, RN, PhD, CNE
Revision Dates:	08-12
Pilot testing:	9-09 SJSU
QSEN revision:	08-12 C. O'Leary-Kelley RN, PhD, CNE

Estimated Scenario Time: 15-20 minutes   Debriefing time: 30-40 minutes

Target group: Fundamentals and beginning Medical Surgical Nursing students, new grads,
Core case: Post-operative management; clinical decision making in evolving case

QSEN Competencies:

- Patient Safety
- Teamwork and Collaboration
- Patient Centered Care

Brief Summary of Case: First part of a 3-part evolving scenario of a patient after abdominal surgery. The patient is 65-year-old female who is admitted to the medical-surgical telemetry unit from the PACU. The patient is status post total abdominal hysterectomy. The RN on the unit receives report from the PACU nurse who remains in the room for the first few minutes. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member.
The purpose is to ensure that the learners recognize signs of airway compromise in a fresh post-operative patient. Learners must call for assistance and institute measures to stimulate the patient.

EVIDENCE BASE / REFERENCES

Hoch, C. R. (2011). Nursing Management: Postoperative Care. In S. L. Lewis, S. R. Dirksen, M. M. Heitkemper (Eds.), *Medical - surgical nursing: Assessment and management of clinical problems* (8th ed. pp. 366 – 382). St. Louis: Mosby.

Cronenwett, L., Sherwood, G., Barnsteiner, J. et al. (2007). Quality and safety education for nurses. *Nursing Outlook*, 55(3), 122-131. doi:10.1016/j.outlook.2007.02.006

2012 National Patient Safety Goals (Hospital) retrieved from: http://www.jointcommission.org/assets/1/6/2012_NPSG_HAP.pdf

ALL DATA IN THIS SCENARIO IS FICTITIOUS

SECTION II: CURRICULUM INTEGRATION

A. SCENARIO LEARNING OBJECTIVES
Learning Outcomes
1. Provide nursing care that promotes safety and minimizes risk of error.
2. Apply clinical decision making skills in interpreting and analyzing data in evolving situations.
3. Prioritize interventions to provide care that is safe and patient-centered.
4. Communicate effectively with members of the inter-professional team.
Specific Learning Objectives
1. Identify findings from a physical assessment that demonstrate risk of complications in a postoperative client.
2. Demonstrate accurate assessment of the client with a focus on the respiratory system.
3. Identify and interpret significant assessment findings requiring immediate reporting and/or intervention.
4. Accurately prioritize immediate interventions required for a client with an unexpected change in status.
5. Evaluate effectiveness of interventions by reassessing critical parameters.
6. Effectively communicate change in status to physician/charge RN/RT utilizing SBAR tool.
7. Effectively communicate with client/family throughout simulation to keep informed and relieve anxiety.
8. Apply safety and infection control measure appropriate to situation.
Critical Learner Actions
1. Wash hands, introduce self, identify client (w/2 identifiers) upon entering room.
2. Perform complete assessment and documentation.
3. Recognize decreased responsiveness and stimulate the patient.
4. Report findings to charge nurse/ MD using SBAR.
5. Apply oxygen per agency protocol.
6. Provide support to family member.

B. PRE-SCENARIO LEARNER ACTIVITIES	
Prerequisite Competencies Required prior to participating in the scenario	
Knowledge	Skills/ Attitudes
❑ Postoperative complications in older adults	❑ Airway management
❑ Current National Patient Safety Goals	❑ Significance of abnormal assessment findings
❑ Airway protection	❑ Therapeutic communication in acute situations
❑ Structured Communication Tools (SBAR)	❑ Request for assistance in escalating situations
❑	❑ Uses SBAR to give report
❑	❑ Airway adjuncts and oxygen therapy

SECTION III: SCENARIO SCRIPT

A. Case summary
This case presents a female, 65-year-old, retired college professor who has just been admitted to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy for dysfunctional uterine bleeding. The RN on the unit receives report from the PACU nurse who remains in the room for the first few minutes. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member.

B. Key contextual details
Learners receive report from the PACU nurse who reports that the patient was stable in the immediate post-operative period. The patient is lethargic but arousable at first. After the first few minutes, the patient becomes less responsive and makes loud snoring respirations indicating airway compromise. Learners must stimulate the patient vigorously and call for assistance.

C. Scenario Cast		
Patient/ Client	❑ High fidelity simulator	
	❑ Mid-level simulator	
	❑ Task trainer	
	❑ Hybrid (Blended simulator)	
	❑ Standardized patient	
Role	Brief Descriptor (Optional)	Confederate (C) or Learner (L)
RN 1	Regular staff	Learner
RN 2	New RN orienting to unit	Learner
Family member	Concerned re: pt. sleepiness	scripted L or C

D. Patient/Client Profile

Last name:	Phillips		First name:	Anastasia
Gender: F	Age: 65	Ht: 66”	Wt: 150#	Code Status: Full
Spiritual Practice: Protestant		Ethnicity: White		Primary Language spoken: English

1. History of present illness

Dysfunctional uterine bleeding x 6 months. Patient elected for hysterectomy.

Primary Medical Diagnosis	Post menopausal uterine bleeding

2. Review of Systems	
CNS	A & O x4
Cardiovascular	RRR; hx of hypertension; BP 130/90
Pulmonary	Lungs clear to auscultation
Renal/Hepatic	Labs normal
Gastrointestinal	Abdomen soft, round, distended
Endocrine	
Heme/Coag	Labs normal
Musculoskeletal	Moves all extremities; osteoarthritis in hands bilaterally
Integument	Intact, no lesions
Developmental Hx	
Psychiatric Hx	none
Social Hx	One glass red wine per day; no illicit drugs, married with grown children
Alternative/ Complementary Medicine Hx	none

Medication allergies:	NKDA	Reaction:	
Food/other allergies:		Reaction:	

3. Current medications	Drug	Dose	Route	Frequency
	Lisonopril	10 mg	PO	Daily in a.m.
	Ibuprofen	200 mg	PO	Q6h prn for pain

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4. Laboratory, Diagnostic Study Results					
Na: 140	K: 4.0	Cl: 102	HCO3: 23	BUN: 26	Cr: 0.9
Ca:	Mg:	Phos:	Glucose: 96	HgA1C:	
Hgb: 10	Hct: 32	Plt: 200,000	WBC: 8000	ABO Blood Type: O+	
PT	PTT	INR	Troponin:	BNP:	
Ammonia:	Amylase:	Lipase:	Albumin:	Lactate:	
ABG-pH:	paO2:	paCO2:	HCO3/BE:	SaO2:	
VDRL:	GBS:	Herpes:	HIV:		
CXR: clear; no infiltrates		ECG: NSR 80 pbm; no ectopics			
CT:		MRI:			
Other:					

E. Baseline Simulator/Standardized Patient State
(This may vary from the baseline data provided to learners)

1. Initial physical appearance	
Gender: F	Attire: Patient Gown

Alterations in appearance (moulage):

Abdominal dressing to abdomen (small amount sero-sang drainage present); sterile 4x4s available near bedside; wig; eyeglasses

x	ID band present, accurate information		ID band present, inaccurate information		ID band absent or not applicable
x	Allergy band present, accurate information		Allergy band present, inaccurate information		Allergy band absent or not applicable

2. Initial Vital Signs Monitor display in simulation action room:						
	No monitor display	x	Monitor on, but no data displayed		Monitor on, standard display	

BP: 112/70	HR: 80	RR: 14	T: 98.8	SpO2: 95%
CVP:	PAS:	PAD:	PCWP:	CO:
AIRWAY:	ETC02:	FHR:		
Lungs: Sounds/mechanics	Left:		Right:	
Heart:	Sounds:	S1, S2 – no ectopy or murmurs		
	ECG rhythm:	NSR		
	Other:			
Bowel sounds:	Absent immediate post-op		Other:	

3. Initial Intravenous line set up							
	Saline lock #1	Site:					IV patent (Y/N)
X	**IV #1**	Site:	RA	Fluid type: LR	Initial rate: 100 ml/hr		IV patent (**Y**/N)
	Main						
	Piggyback						
	IV #2	Site:		Fluid type:	Initial rate:		IV patent (Y/N)
	Main						
	Piggyback						

4. Initial Non-invasive monitors set up					
x	NIBP	x	ECG First lead:		ECG Second lead:
x	Pulse oximeter		Temp monitor/type		Other:

5. Initial Hemodynamic monitors set up					
	A-line Site:		Catheter/tubing Patency (Y/N)	CVP Site:	PAC Site:

6. Other monitors/devices				
x	Foley catheter	Amount: 200 ml	Appearance of urine: clear yellow	
	Epidural catheter	Infusion pump:	Pump settings:	
	Fetal Heart rate monitor/tocometer		Internal	External

Environment, Equipment, Essential props

Recommend standardized set ups for each commonly simulated environment

1. Scenario setting: (example: patient room, home, ED, lobby)

Medical/surgical telemetry unit

2. Equipment, supplies, monitors (In simulation action room or available in adjacent core storage rooms)							
	Bedpan/ Urinal		Foley catheter kit		Straight cath. kit	x	Incentive spirometer
x	IV Infusion pump		Feeding pump		Pressure bag		Wall suction
	Nasogastric tube		ETT suction catheters	x	Oral suction catheters		Chest tube insertion kit
	Defibrillator		Code Cart		12-lead ECG		Chest tube equip
	PCA infusion pump		Epidural infusion pump		Central line Insertion Kit		Dressing Δ equipment
	IV fluid Type: LR				Tubes/drains Type:		Blood product ABO Type: # of units:

3. Respiratory therapy equipment/devices							
x	Nasal cannula		Face tent	x	Simple Face Mask	x	Non rebreather mask
x	BVM/Ambu bag		Nebulizer tx kit		Flowmeters (extra supply)		

4. Documentation and Order Forms							
x	Health Care Provider orders	x	Med Admin Record	x	H & P		Lab Results
x	Progress Notes		Graphic record	x	Anesthesia/PACU record		ED Record
	Medication reconciliation		Transfer orders		Standing (protocol) orders		ICU flow sheet
	Nurses' Notes		Dx test reports		Code Record		Prenatal record
	Actual medical record binder, constructed per institutional guidelines				Other Describe:		

5. Medications (to be available in sim action room)								
#	**Medication**	**Dosage**	**Route**		**#**	**Medication**	**Dosage**	**Route**

<table>
<tr><th colspan="4">CASE FLOW / TRIGGERS/ SCENARIO DEVELOPMENT STATES</th></tr>
<tr><td colspan="4">Initiation of Scenario: This case presents a female, 65-year-old retired college professor who is admitted to the medical-surgical telemetry unit from the PACU. The patient is s/p total abdominal hysterectomy for dysfunctional uterine bleeding. The surgeon was not able to do a vaginal approach. The RN on the unit receives report from the PACU nurse who remains in the room for the first few minutes. Report includes stable vital signs, responsive to voice, and a dressing clean dry and intact. Pt has patent foley catheter in place. The patient's family member is at the bedside. A second RN is also present as she/he is orienting to the unit as a new staff member.</td></tr>
<tr><th>STATE / PATIENT STATUS</th><th colspan="3">DESIRED LEARNER ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</th></tr>
<tr><td>1. Baseline

Pt. lying in bed w/HOB elevated. Responds briefly to questions but is sleepy.

Denies pain "2/10" if assessed</td><td>Operator

BP – 112/70
HR – 80
RR – 14
T – 98.8 F.
O2 sats – 94% on2/L NC

Triggers: complete actions within 5 minutes</td><td>Learner Actions:

Wash hands / ID patient

Introduce RNs to pt and family

Begin focused post-operative assessment/ or direct other RN
- Obtain vital signs
- Assess pain
- Assess respiratory and cardiac status
- Assess IV and incision site</td><td>Debriefing Points:

NPSG's to prevent infection

Potential co-morbidities in the 60+ age group surgical patient

Pain assessment

Nursing responsibilities in the post-operative period</td></tr>
</table>

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STATE / PATIENT STATUS	DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE		
2. Patient becomes more difficult to arouse -Falls asleep and snores when not stimulated (family member is concerned; asks "Why is my mother/aunt so sleepy?")	**Operator:** B/P 120/80 HR: 98 RR: 10 T: 98.6° F O2 Sat: 92% RA **Triggers:** Arouses/stimulates sedated patient - go to state 3 Failure to stimulate - go to state 4	**Learner Actions:** Complete post-op assessment. Document vital signs Notice change in LOC and difficulty staying awake Attempt to arouse/stimulate patient vigorously - Raise HOB - Increase 02 if needed Notify Charge RN/MD using SBAR Provide calm explanation to family member, or delegate to other staff	**Debriefing Points:** Complications in fresh post-operative patients Signs of airway compromise Acceptable methods of stimulation in patient with decreased responsiveness Recognize family member's concern and the need for reassurance/information

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<table>
<tr><th>STATE / PATIENT STATUS</th><th colspan="3">DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</th></tr>
<tr><td>3. (rescue)

Increased responsiveness; more conversant</td><td>Operator:
B/P 120/80
HR:80
RR:18
T: 98.6° F
O2 Sat: 96% RA

Triggers: continued monitoring / stimulation</td><td>Learner Actions:

Continue to assess patient LOC, vital signs, pain level

Stimulate / arouse patient as needed to maintain patent airway and optimal respiratory status</td><td>Debriefing Points:

RN role in assessing and maintaining airway patency

Potential complications in post-operative patients</td></tr>
</table>

<table>
<tr><th>STATE / PATIENT STATUS</th><th colspan="3">DESIRED ACTIONS & TRIGGERS TO MOVE TO NEXT STATE</th></tr>
<tr><td>4. (failure to rescue)

Decreased responsiveness; loud snoring.

Arouses briefly but returns to sleep if not vigorously stimulated.</td><td>Operator:

B/P 130/90
HR: 100
RR: 8
O2 Sat: 90%

Triggers: Prompt intervention leading to recovery</td><td>Learner Actions:

Notice acute change in LOC and Decreased airway patency

Attempt to arouse/stimulate patient vigorously
- Raise HOB
- Increase 02

Call for help

Notify Charge RN/MD using SBAR</td><td>Debriefing Points

Prompt action in recognizing airway compromise

Potential complications: respiratory failure</td></tr>
<tr><td colspan="4">Scenario End Point:</td></tr>
<tr><td colspan="4">Suggestions to <u>decrease</u> complexity: other team members (Charge RN or MD) can enter room “making rounds” may provide cues.
Suggestions to <u>increase</u> complexity: Add more abnormal assessment findings (bleeding at incision) or add more complex pre-existing conditions.
Objectives will be determined by the level of learner.</td></tr>
</table>

ALL DATA IN THIS SCENARIO IS FICTITIOUS

APPENDIX A: HEALTH CARE PROVIDER ORDERS

Patient Name: Phillips, Anastasia **DOB: 1/15/XX** **Age: 65** **MR#: PCS654321**	**Diagnosis: s/p total abdominal hysterectomy**

†No Known Allergies
†Allergies & Sensitivities   Code Status: FULL

Date	Time	**HEALTH CARE PROVIDER ORDERS AND SIGNATURE**
		Diet: sips of water, advance to clear liquids as tolerated
		Activity: Out of bed tonight
		Post-op vital signs q 2 hours x2, then q4 hours
		IV: LR at 100ml/hour
		Compression stockings and SCDs
		Indwelling foley catheter to gravity drainage
		I & O per routine
		O_2 2-4 liters/min per NC to maintain $SpO_2 \geq 92\%$
		Incentive Spirometer 10x qhr while awake
		Medications:
		Morphine Sulfate 2 mg IV q4 hrs prn moderate to severe pain
		Vicodin 5/500 2 tabs q4hrs prn pain
		Ancef 1 gm IVPB q 8 hrs x3 doses
		Transfer to telemetry unit
Signature		*Georgina Johnson MD*

APPENDIX B: Digital images of manikin and/or scenario milieu	
Insert digital photo here	**Insert digital photo here**
Insert digital photo here	**Insert digital photo here**

APPENDIX C: DEBRIEFING GUIDE

General Debriefing Plan			
☐ Individual	☐ Group	☐ With Video	☐ Without Video
Debriefing Materials			
☐ Debriefing Guide	☐ Objectives	☐ Debriefing Points	☐ QSEN

QSEN Competencies to consider for debriefing scenarios		
☐ Patient Centered Care	☐ Teamwork/Collaboration	☐ Evidence-based Practice
☐ Safety	☐ Quality Improvement	☐ Informatics

Sample Questions for Debriefing

1. How did the experience of caring for this patient feel for you and the team?
2. Did you have the knowledge and skills to meet the learning objectives of the scenario?
3. What GAPS did you identify in your own knowledge base and/or preparation for the simulation experience?
4. What RELEVANT information was missing from the scenario that impacted your performance? How did you attempt to fill in the GAP?
5. How would you handle the scenario differently if you could?
6. In what ways did you check feel the need to check ACCURACY of the data you were given?
7. In what ways did you perform well?
8. What communication strategies did you use to validate ACCURACY of your information or decisions with your team members?
9. What three factors were most SIGNIFICANT that you will transfer to the clinical setting?
10. At what points in the scenario were your nursing actions specifically directed toward PREVENTION of a negative outcome?
11. Discuss actual experiences with diverse patient populations.
12. Discuss roles and responsibilities during a crisis.
13. Discuss how current nursing practice continues to evolve in light of new evidence.
14. Consider potential safety risks and how to avoid them.
15. Discuss the nurses' role in design, implementation, and evaluation of information technologies to support patient care.

Notes for future sessions: